Women's Studies International Forum 33 (2010) 180–187

Contents lists available at ScienceDirect

Women's Studies International Forum

journal homepage: www.elsevier.com/locate/wsif

The right to health: Overcoming inequalities and barriers to women's health in Papua New Guinea

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ARTICLE INFO

Available online 13 January 2010

SYNOPSIS

Few attempts have been made to examine women's health in Papua New Guinea using a human rights framework that puts women and their experiences with fear, abuse, oppression and discrimination, at the core of women's health. This article describes the findings of a qualitative study that examined the key determinants of women's poor health and the level of access to appropriate health care in relation to the right to health. Three main themes emerged as significant barriers to health; 1) violence 2) heavy workload and lack of economic opportunities 3) limited use of health services. The findings show that women's familial, socioeconomic status and productive roles intertwine to threaten their right to health. These findings should challenge health practitioners and policy makers in Papua New Guinea to put questions of power, resources, vulnerability and discrimination at the core of women's health programming.

Introduction

The right to the highest attainable standard of health is among a host of interdependent and indivisible rights guaranteed to all human beings under international treaties. The right to health is closely related to and dependent on other human rights that are determinants of health, including the right to life, liberty and security of person, the right to adequate food, housing and social security and the right to an education. Individuals rarely suffer neglect or violation of one right in isolation (Gruskin, Mills & Tarantola, 2007). The human rights aspects of health and the connection between the right to health and economic and social conditions was clarified in the International Covenant on Economic, Social and Cultural Rights ratified in 1976 and Article 12 asserts that "it is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (ICESCR, 1976). This included measures to improve medical care together with a focus on health-enabling factors outside the medical realm (Solar & Irwin, 2007).

Examining the right to health

Multiple human rights documents which include the International Covenant on Civil and Political Rights (1976), Convention against All Forms of Discrimination against Women (1981), Convention on All Forms of Racial Discrimination (1969) and Convention on the Rights of the Child (1990), promote and protect human rights as a prerequisite to health and well-being. Every government is now party to at least one treaty incorporating the right to health. The right to the highest attainable standard of health makes governments responsible for the prevention, treatment and control of diseases and for the progressive correcting of conditions that may impede the realisation of the right to health (Braveman & Gruskin, 2003).

The determinants of health, stemming from underlying social stratification, and the level of access to affordable, appropriate and quality health care contribute to a person's ability to achieve the highest attainable standard of health. Globally, in most countries, there are those who enjoy a higher standard of health and quality of services and those who, due to a range of, civil, political, economic, social and cultural factors are more vulnerable to ill-health and have inadequate access to health-related services. Research has documented a relationship between health inequalities and inequalities in income,

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doi:10.1016/j.wsif.2009.12.006

education, occupational status and employment status (Bruner & Marmot, 2006; Pietilä & Rytkönen, 2008; Siegrist & Theorell, 2006) and health-related mediators of inequality and inequity include health behaviours, psychosocial resources, coping strategies and social support (Denton, Prus & Walters, 2004; Moss, 2002). Of critical importance is the recognition of gender as a key determinant of health inequities. While many of the social determinants of health are the same for women and men, because of the interaction of these determinants with gender, women and men experience health and illness differently (Cohen, 1998).

Where do women's rights fit?

The Cairo International Conference on Population and Development (1994) and the Platform for Action of the Fourth World Conference on Women in Beijing (1995) were instrumental in solidifying the link between human rights and women's health, a link reinforced in international consensus documents (Gruskin & Tarantola, 2005). The Beijing report endorsed an approach to women's health to improve the status of women and women's empowerment through education, employment and involvement in social development. Significant to this changing model of women's health was the goal of improving human rights for women and targeting the discrimination and gender inequalities that underlie women's health, including a focus on violence against women and increasing access to justice (Meleis & Im, 2002; Moss, 2002). There was a move away from seeing women's health as a biological problem that could be addressed solely through improved medical technologies, to a holistic and contextual model that recognised health as a product of the same forces that structured a woman's relationship to the physical and social world around her and could be addressed through social policies, programmes and activist movements (Freedman, 1999a). The commitments to the advancement of women given at Beijing and the recognition of women's human rights spelled out in the Convention against All Forms of Discrimination against Women (CEDAW) and other human rights instruments since Beijing have not been realised in Papua New Guinea (Amnesty International, 2006). Women living in poverty continue to experience persistent inequalities and inequities and have little formal or informal power to effect structural change to improve their health. Unless international commitments and national policy documents are revisited and monitored carefully and the information used to hold governments to account, progress toward gender equality will be constrained and the urgent needs of women will continue to be ignored (Meleis, 2005).

Recognising the right to health in PNG

Papua New Guinea (PNG) has a high level of aid dependency (Corner, 2008). Australia wields enormous influence over PNG because of the two countries' proximity, colonial history and Australia is Papua New Guinea's largest foreign donor. The Australian Government will spend AUD $377 million in Papua New Guinea in 2009–2010 (AusAID, 2009). The size of this assistance alone allows the Australian Agency for International Development (AusAID) to dominate and monopolise the development and political discourse. Despite the severity of human rights abuses in PNG, the Australian government does not consistently press the government of PNG for improved human rights or integrate human rights in discussions of poverty reduction and sustainable development strategies (Asian Centre for Human Rights, 2008).

Despite an active women's rights movement in the Pacific region, women's issues are barely represented in national politics and government policies. Women in Papua New Guinea are excluded from decision-making at all levels, and the political landscape is dominated by men. "Traditional" culture and customary practice is invoked to justify gender discrimination, subordination and disqualification from political, bureaucratic and modern economic spheres (Macintyre, 2000). Two major studies on human rights in Papua New Guinea show widespread and systemic patterns of abuse perpetuated by police and endemic violence against women and children by male relatives and both known and unknown perpetrators (Amnesty International, 2006; Human Rights Watch, 2005). The threat of gender-based violence, particularly sexual violence, impacts on a woman's ability to move freely in the community, to use public transport, to access health and education services, and to travel to market or to the workplace (Amnesty International, 2006). Researchers have shown that women in Papua New Guinea experience high levels of intimate partner violence (Bradley, 1994; Lewis, Maruia & Walker, 2008; Toft, 1986). These women are denied the right to access justice, to receive reparation or to see their perpetrator punished. Widespread violence and abuse, together with a weak health system, high levels of poverty and socioeconomic inequity limits Papua New Guinea's ability to meet its commitment to the Millennium Development Goals (MDGs) and contributes to women's poor health indicators.

Maternal mortality has gained global prominence as a human rights issue, indeed the commitment to improve maternal health that was made in the Millennium Declaration has become a central platform to international development efforts. In Papua New Guinea women's health statistics are a pressing public-health concern. The life expectancy of women is estimated to be 61 years (World Health Organisation [WHO], 2006). Women's maternal mortality rates in PNG are the highest in the Pacific region (870/100,000), compared with 236/100,000 in the Solomon Islands and 50/100,000 in Fiji (World Health Organisation/Western Pacific Regional Office [WHO/WPRO], 2008). A woman from Papua New Guinea is 200 times more likely to die in childbirth than a woman in Australia (4/100,000). Obstetric causes were the fifth leading cause of morbidity and inpatient care between the years 2000 and 2004, with a prevalence of 266/100,000 (WHO/WPRO, 2008).

A woman's right to health is not just about access to maternal and reproductive health care. Women in Papua New Guinea are dying at high rates because of chronic and entrenched inequalities, because women's health is not valued in itself and the status of women is lower than that of men (Macintyre, n.d). Few attempts have been made to examine women's health in Papua New Guinea using a human rights framework that puts women and their experiences with fear, abuse, oppression and discrimination at the core of women's health. This entails an examination of

women's health within the broader context of human development in order to underscore the relevance of an array of factors, well beyond the health sector, that impact on overall well-being and health.

Study setting

This paper is based on field work conducted in the Wosera district, East Sepik Province of Papua New Guinea from late 2005 to early 2006. The Wosera district is part of the Abelam linguistic group and is one of the least developed areas of Papua New Guinea. Malaria is endemic and is the second leading cause of medical admissions and the third leading cause of death (Genton et al., 1995). In 2004 antenatal coverage in the Wosera was recorded at only 48%, (National Department of Health, 2005), below the national average of 58% recorded in 2006 (WHO/WPRO, 2008). Of the rural citizen population in the East Sepik in 2000 only 42.7% of women were literate, lower than the national rate of 46.3% (National Statistics Office, 2002, p.38).

The participants in this study lived within one hour's walking distance from a sub-health centre run in association with the local Catholic mission. It was staffed by five to seven people, consisting of a minimum two nurses and several community health workers trained in basic clinical and antenatal care, and with overall management provided by a Health Extension Officer (HEO). It offered primary health services at their outpatient department, a 12 bed inpatient ward and delivery room.

Methods

A qualitative approach was used for data collection and analysis and included in-depth interviews, ranking exercises, focus group discussions (FGD) and photo narratives, a methodology similar to a FGD but instead photos were used of women at different stages of their lives (child, adolescent, adult) to guide the discussion. To understand the diverse health needs of women and the key determinants of health across the lifespan, 33 young women (18 to 24 years), 27 adult women (25 to 44 years) and 10 older women (over 44 years) participated in the study. Single and married participants, unmarried mothers, school attendees and young women out of school were actively approached and made aware of the study. Discussions were held at times relevant to the different needs and responsibilities of participants.

A focus group was held with six young men and eight adult men respectively. Male and female participants were recruited using snowball, purposive and opportunistic techniques. Ten community members were purposively sampled for their diverse experience of women's health issues. The sampling method used in the study was most acceptable for obtaining information to understand the local context, it was unobtrusive, allowed for the examination of emerging themes and it took account of the limited time frame.

The research was conducted with a total of 94 respondents who provided informed verbal consent. Discussions were held in *tok pisin*, the local lingua franca, by the lead researcher and research assistant and translation was provided by the research assistant if participants preferred to speak their local language (a dialect of the *Ndu* family of languages). Questions focused on what being healthy meant to participants and what was necessary for them achieve good health. The barriers to health and the options available to women to overcome poor health were also explored. Interviews lasted a maximum of 1 h, with group discussions taking somewhat longer, continuing for up to 2 h in most cases. In-depth interviews and focus group discussions were recorded and transcribed. Data analysis initially involved the reading of field notes and the discussion of key findings. Codes were applied to segments of transcribed data to identify emerging themes, unanticipated findings and areas where further questioning was required. The software programme Atlas-ti was used to manage the data analysis process. Ethical approval was obtained in accordance with the requirements of the university's Human Ethics Committee and the Papua New Guinea Medical Research Advisory Committee. To ensure anonymity, pseudonyms are used throughout this paper.

Findings

The themes that emerged from the research depict narratives of multiple health needs and show an unequal burden of women's domestic and productive roles, responsibilities and obligations. Three main themes emerged in the analysis of women's discussions of their health and its place within the social, cultural and economic context of their lives: 1) violence 2) heavy workload burden and lack of economic opportunities 3) limited use of health services. It is not the intention of this paper to catalogue all the ways in which these issues impact on women's health. Rather, the point is to reaffirm that in any given place and time, women's health cannot be understood in a way that is detached and separated from these kinds of social forces (Freedman, 1999b).

Barriers to women's right to health in PNG

Violence

Violence affected women's lives throughout the lifecycle. Women experienced violence at the hands of their parents, brothers, sons, and by their husbands and in-laws in marriage. As described elsewhere in Papua New Guinea (Macintyre, n.d; Wardlow, 2006), women experienced a high degree of surveillance, chastisement and social exclusion if the boundaries of custom and convention were breached. The main reasons young women gave for being beaten by their parents or male siblings was that they had been caught socialising with an un-related young man in private, which was an unacceptable modern practice, as was wearing revealing clothes, drinking alcohol, smoking marijuana or going to a “six to six” disco party.

A premarital pregnancy took the familial abuse of a young woman to another level and could range from sustained verbal and emotional abuse to physical violence, particularly in cases where no marriage ensued. Consistent violent treatment could result in a young woman leaving the parental home to stay, if possible, with supportive relatives. Ideally a young woman's return to the family unit would be negotiated, because in Alana's experience, the alternative had serious social, economic and health consequences.

> When I was older, after I had started menstruation, I did what I wanted, if I wanted to go to a dance I would, whatever I wanted to do I would. Being able to go to a dance is important. I would come back to the house and my father would get a stick, spear, whatever and chase me. This continued on and on and he made me so wild that I left and moved from house to house until I ended up how I am, pregnant. So life is really hard now.

Male control over women emerged as a strong theme in discussions of intimate partner violence. Some adult women felt devalued by their husbands. Payment of brideprice entailed 'ownership' of a woman by her husband (Amnesty International, 2006; Eves, n.d.; WHO, 2005), and she was seen as "*samting nating,*" (unimportant, meaningless) other than to fulfil her responsibilities and obligations in marriage. The impact of this treatment on women's self-esteem did not go unnoticed by Sally who explained:

> Sometimes men want to be the head, they want to be the boss and put women down. When I want to look after myself and dress well, my husband is jealous for no reason. He does that to me and puts me and my ideas down so that I will become a "rubbish" woman. That is what men do.

As described elsewhere, the concerns and anxieties that arose from infidelity, polygamy and promiscuity were fuelling violence within communities (Haley, 2008; Haley & Muggah, 2006). Male suspicion of infidelity and jealousy meant a woman's movements were restricted, as if she was "*long kalabus*" (in jail), her appearance was scrutinised and as a community police officer identified, the end result could be a man verbally and physically assaulting his wife.

> I see this happening a lot. Men hit their wives for this reason. They hit them because they are jealous, for no reason, about other men. A lot of men do it, especially young men. Young married men.

Men however claimed it was customary practice and their right to engage in multiple unions. Their descriptions of polygamous relationships however were quite different from the traditional pattern of polygamous marriage practiced by men who had significant resources and had gained status and prominence in middle life. For the men in this study polygamy was about sexual prowess and male control. Women were blamed for their husbands' infidelity and for a man taking a second wife because, as a young man mentioned, it was because she was "not looking after her husband properly (not fulfilling domestic obligations), not following her husband's wishes, or she was unable to bear children. Polygamy was seen by women to have inequitable outcomes due to men not meeting their obligations and fairly distributing their time, labour and financial and material resources among their wives and children. The following quotation from a nurse acknowledges the relationship between violence, polygamy and poor health.

> In terms of women's health, what I have seen over the past months is that for some women, some of them don't live well because their husbands have married another woman and this causes violence within the family.

Esther stated that "these men from here, they are the bosses. We are their slaves." She recognised that men had greater freedom than women and expected their wives to meet their demands without question. Rather than working in partnership with a man who took the lead to provide for his family, women were expected to "come underneath" men. Women recognised that not all men abused their wives and some couples did of course achieve a marriage where they worked side by side and cooperated on joint endeavours. Participants claimed that a man who assisted his wife to meet the demands of her daily workload and shared his earnings was also perceived to be the type of man who would never mistreat or "hit his wife."

Men and women agreed that men perform less labour relative to women and women received variable support from their husbands with subsistence activities. Although Adam recognised he was failing in his domestic obligations, as the following discussion shows, there could be serious social consequences if a woman questioned her position. A woman could expect a "panel beating," a colloquialism for physical violence, if she complained about her multiple responsibilities or her husband's inadequacies.

> Adam: When a man doesn't follow his wife to the garden there will be problems. When it's late afternoon and she returns from the garden and you ask your wife for food she will ask "did you follow me? Did you help me with my work today?" This is where the problems arise, a lot of marriages break up over these issues. So at least we must work together with our wives.
> Tony: If she doesn't cook our food then she will get a panel beating.
> Andrew: That's where the problems start.

The physical and mental health implications of violence against women in the Wosera were significant. Women were beaten, verbally abused and locked out of their houses. Young and adult women recalled violent encounters that involved the destruction of their property, such as pots, plates and the ripping and burning of their clothes. If a woman refused to have sex with her husband, her "disobedience" could be physically and verbally admonished. A suspected infidelity or a woman not meeting her marital obligations were excuses used by men to rationalise the violence in public. A woman who was unable to become pregnant was also the object of her husband's anger since "marriage is to have children."

Several women in this study feared for their lives. Remaining in a violent relationship could result in serious injury as Angela and Beryl, two young married women discussed, or possible death, either at the hand of their husband (Kate) or by suicide (Beryl):

> Kate: It was at a level that he would kill me. So that wasn't good so I slowly began to leave him. If I stayed with him and over time he became angrier and angrier, he could have killed me.
> Beryl: We run away and go and stay with our parents or we go to court. Sometimes we think about hanging ourselves. He beats me often, so I get these kinds of thoughts. I will hang myself and end my life.

Respondents identified that leaving a violent husband was not without its difficulties. The power imbalance and the socio-cultural and economic consequences of leaving a relationship that was perceived as risky could be far worse that the health risks of staying in the relationship. A woman's decision to leave was often dependent on whether her natal kin would provide her with social and economic assistance. Patrilineal structures also determined that a child was a member of their father's clan, with associated land rights and obligations. Esther took this into account when discussing her desire to leave an abusive polygamous relationship, in which she was the second wife.

> I think a lot about leaving my husband, but then I think about my son. Because of our custom, I have a lot of brothers and if I take my son with me, there might be a problem in the future, there will be a lot of males and my son won't have a good quality of life. That's what I think about. I will stay with my husband until my son is 5 years old, then I will leave him with his father.

The findings documented here are consistent with the most thorough study of intimate partner violence conducted in Papua New Guinea by the Law Reform Commission, which showed that the two most common triggers of domestic disputes were sexual jealousy and a wife's inability to meet marital obligations such as cooking, cleaning and child-care (Toft, 1986). The women in this study were victims of male control, jealousy and promiscuity. Women lived in relationships characterised by physical and emotional abuse. These findings illustrate the struggle of women to keep themselves healthy when confronted with a harsh reality and the abuse of their rights in their daily lives.

Workload burden and lack of economic opportunities

Women repeatedly stated that their workload was a major constraint to their health. The multiple responsibilities of a woman's workload involved the production of food crops, such as sweet potato, taro, corn and sago, firewood and water collection, the provision and cooking of food for domestic consumption and all laundry and child-care activities. A woman's workload burden extended to the constant struggle to find money for household items, clothing and children's school fees.

A man's lack of support and assistance to his wife to meet the demands of daily life were a constant cause of marital disputes. Women were aware of the inequities within the marital relationship and the unachievable expectations that their husbands placed on them to meet a heavy workload without assistance. An excuse regularly given by men was that a woman's workload was "*wok blong ol meri,*" (women's work), and woman's role in marriage was to work hard and bear children and "not to relax."

In the two decades since the Law Reform Commission study, this research suggests that the changing attitude of women regarding social and domestic obligations noted among urban women is becoming apparent in rural areas. As Toft (1986, p.15) found, urban women "have reassessed their role and rejected their previous subordinate position." The women in this study regularly expressed concern about their position and were less prepared to accept their subservient status. Carly questioned for example, "why have I married this kind of man? One child will cry, another one I will put in the sling, another on my shoulders. It's really hard." It is also possible that the less submissive stance of women was causing younger men to react by asserting their authority in the marital relationship through violence.

The burden of a heavy workload was exacerbated by having to provide for a large family. Twelve of the 33 young adult women had one or more child. Adult women had an average of 3.9 children, increasing to an average of 5.9 for older women. It is not surprising that women complained about the physical and economic strain of having many children, since they were ultimately responsible for meeting all domestic needs. Research has shown that children from large families are also likely to be undernourished, undereducated and poor (Defo, 1997).

Women of all age groups consistently described the stress, anxiety and worry they experienced about meeting the financial and physical demands of their daily lives. The circumstances of want created an oppressiveness in young women's lives (Polakoff & Gregory, 2002). Young women struggled to meet their basic needs on a severely restricted budget. Adult women faced persistent demands and expectations to provide for their family in circumstances that were often isolating and beyond their control. The emotional problems and worry that was described in adult women's accounts of their health was clearly emerging in young women's narratives, with young women exposed to factors, such as social and economic stress, that affected their confidence, sense of independence and self-esteem. All participants described the physical manifestations of their stress and anxiety, which included headaches, inability to sleep, dizziness and weakness. Married women also complained that exhaustion and chronic aches and pains in their legs, arms, shoulders and lower back were evidence of the heavy physical toll of their constant workload demands.

Access to essential health services

The women in this study faced a formal health care system that did little to meet the physical, emotional and mental health needs they identified and which gender-sensitive research highlights. A combination of government, churches and private organisations provide health services in PNG. Besides the formal health services, village health volunteers, traditional birth attendants and traditional healers also provide health services in some rural communities (United Nations, 2001). The 1974–78 National Health Plan committed the country to primary health care (PHC) (Connell, 1997) and established aid posts in rural areas, staffed with community health workers (CHWs) offering basic services — anti-malarial tablets, aspirins and treatments for cuts and sores.

At the time of this study, the majority of the aid posts in the Wosera had collapsed, either closed or were not staffed or supplied with medicine or equipment. There was no doctor available in the entire Wosera district and serious medical cases were referred to Maprik District Hospital, half an hour drive away, or to Wewak Provincial Hospital, at least 3 h drive from the Wosera. Women accessed treatment for what they perceived as "minor ailments" from health volunteers, trained as part of the Save the Children Fund, Women and Children's Health Project, or made the hour walk to the locally Catholic-run health centre.

As found in other developing country contexts (Kelaher et al., 1998; Tannenbaum & Mayo, 2003), women faced a system focusing on a singular dimension of health rather than addressing a woman as a whole person. Services for women focused on reproductive health services, namely Maternal and Child Health clinics. As documented elsewhere (WHO, 2003; Wong, Li, Burris & Xiang, 1995), these programmes prioritised infant and child survival to the neglect of women's health and they neither took account of the health needs of women who were not pregnant, nor accommodated women's changing needs throughout their life cycle. Although the two nurses interviewed for this study made a connection between poor living conditions, stress and women's ill-health, a lack of resources, limited staff training and time constraints restricted their capacity to respond to the psychosocial needs of their patients.

The constraints of gender and social, economic and cultural factors resulted in poor and often older women and girls being less likely to have access to appropriate care or to seek adequate treatment (WHO, 2003; Wyn & Solis, 2001). Despite their ailing physical status, older adult women rarely sought treatment from the formal healthcare system, preferring traditional cures or basic treatment offered by the health volunteers. Lack of mobility, limited financial resources and lack of social support were the main factors inhibiting older women's access to health services.

Young women's accounts showed they did not access health care in a safe or comfortable environment. In PNG it used to be law that only married women could receive contraception from government clinics and that both husband and wife had to sign a consent form. Although the law has changed, so that a woman no longer needs her husband's consent, young unmarried women were entirely excluded from accessing family planning, let alone basic relationship advice from the Catholic-run health centre or family planning and health volunteers. Premarital sex was seen as culturally, socially and morally inappropriate and as such young women were labelled as promiscuous and criticised for their family planning requests. The end result was a degrading and insensitive health care encounter for young women. This is consistent with the findings of other studies that show the delivery of health care as being affected by poor communication and information exchange and condescending attitudes of health workers which work to intimidate and shame (Kelaher et al., 1998; Wathen & Harris, 2007).

Although there was a general appreciation expressed by participants about the availability of medicine, the health system was fragmented, involved long waiting times at poorly staffed and under resourced health centres and hospitals and put competing demands on women's time, as Carly's comment typifies:

> Those of us who haven't washed the plates and go to the health centre, we think a lot about these things. We want to go quickly to the health centre, we have to wash the baby's nappies, wash the saucepans and plates. If I go in the afternoon then I will have to cook dinner in the late evening.

A consequence was that adult women delayed seeking medical care and suffered an illness in silence. Although they received little support in their domestic duties, women were expected to meet their responsibilities and not disrupt household organisation. Men were reluctant to allow women to participate in activities that would take them away from the confines of the village or garden and as described elsewhere in PNG, if a woman was not obviously ill and attempted to seek treatment at a clinic alone she would likely be accused of other intentions (Macintyre, 2000). Together with existing barriers to health care such as lack of time, knowledge and financial restrictions, women learnt to prioritise the well-being of others over themselves. Beth's account shows that this could result in self-care neglect.

> We go to the health centre if we are really unwell. But if we are only a little sick we think about work and we go and harvest taro or sago. If we go to the health centre who will be there to help our mothers to do this kind of work?

The health system itself was also responsible for the perpetuation of social inequalities against women. Women who sought treatment for violence-related injuries were made to feel somehow responsible for their perpetrator's actions. This did little to allay Tracy's fear of speaking out against her brother in-law:

> My husband's older brother hit me with a stick. I felt a lot of pain so I came to the health centre. And the nurses asked me “what did you do that made him hit you?” I said, "I don't want to talk about it because it will make him angry again and I'm afraid." I was thinking a lot about that. The nurses forced me to talk though. So I told them that my husband's older brother hit me on my hand and it became very swollen. I couldn't lift it. I was telling the nurse my story and then the nurse responded by saying, “what did you say to him that made him hit you?”

Discussion

This paper has analysed the inequalities at the heart of women's health in Papua New Guinea and that impede the realisation of the right to health. Women's work and the physical burden of women's roles, marriage and threat of violence, and an unresponsive and inappropriate health service are major risk factors for women's health in developing countries (Meleis, 2005; Schoenfeld & Juarbe, 2005). This is consistent with the findings of this study which show that women's familial, productive roles and socioeconomic status intertwined to threaten their health. Women were situated in a social, cultural and economic environment that infringed on multiple rights, sustained unequal power relations and allowed for the perpetuation of violence against women.

Maternal death rates in Papua New Guinea are not declining despite a focus on maternal and child health by health workers, the national government and international aid agencies over a considerable period of time (Byford, 2005). The findings in this paper challenge the assumption that more hospitals and technological interventions will reduce maternal mortality. Women in PNG experience poor health because their health is not valued in itself and because women are discriminated against, abused, expected to meet unrealistic obligations, violated and denied access to appropriate and equitable services on a daily basis.

The findings show that the demands and restrictions that men imposed on girls and women and the threat of violence, if these were ignored or defied, were major factors limiting women's choices and right to health. Similar to Goicolea's (2001) study of Ecuadorian women and their accounts of "machisimo" and its relationship to gender violence, men took a number of actions to prevent their wives and daughters from having contact with those outside the domestic realm, which served to confine women to the narrow limits of their assigned gender role. As described elsewhere (Amnesty International, 2006; Macintyre, 2000; Moss, 2002; Schoenfeld & Juarbe, 2005), the expression of violence took a large toll on the psychological and physical health of the women in this study.

Addressing women's right to health in PNG — using a rights-based approach

The international literature is growing on the ways the gender divide compromises women's ability to access appropriate and equitable health care (Cohen, 1998; Meleis, 2005; Vlassoff & Bonilla, 1994). Instead of viewing health services for women through the lens of reproductive health, biomedical frameworks and the promotion of personal responsibility, a human rights framework would focus on the multiple roles of women and their experiences with fear, vulnerability, exploitation and oppression throughout the life cycle. Services sensitive to gender and human rights would see an improvement in provider knowledge of women's health problems and the socioeconomic factors determining patterns of health and illness, the sharing of information and joint decision-making (Khoury & Weisman, 2002). These would be positive first steps in the attempt to address women's vulnerability to inequitable care across the life span.

The level of violence against women in Papua New Guinea is a major obstacle to development and improvements are critical for progress towards the Millennium Development Goals (Meleis, 2005; WHO, 2005). As long as violence against women and the acceptance of violence more generally in PNG persists, programmes aimed at improving women's economic and social status will be ineffective. The Government of Papua New Guinea, international and national civil society organisations and donor agencies must explicitly recognise that violence against women and the social and economic discrimination of women is a serious violation of human rights and a pressing development issue (Bradley, 1994). A person's gender, marital or relationship status does not change their right to have his or her right to health respected, protected and fulfilled.

The way forward

The major reason women continue to die from pregnancy-related causes in Papua New Guinea is that they are continually discriminated against as women throughout the life span. The severe neglect of women's health is a violation of their human rights (Gruskinet et al., 2008) and this violation must be investigated precisely to determine where the responsibility lies so that appropriate policy changes are introduced as a matter of priority (United Nations, 2006). Because the poor maternal mortality rates in PNG are socially produced, they can only be socially ameliorated, and as such, policies underpinned by the right to health must incorporate other crucial issues of women's health, not least the vital importance of reducing violence and improving the psychosocial health of women. This means that health policies must be centred on human development — equitable, inclusive, non-discriminatory, participatory and evidenced-based — and which alleviate and are responsive to the social inequalities inherent in women's health, inclusive of maternal health. The principles and standards derived from international human rights treaties (both those specifically referring to women and gender, and those directed to civil, political, social, economic and cultural rights generally) should guide policy formulation and intersectoral programming in women's health, in all phases of the programming process (United Nations, 2006).

The poor health statistics and inequalities facing women in PNG must be used as a platform with which to galvanise the Government of Papua New Guinea to develop a legislative framework that takes into account the different and inequitable needs of women and men in allocating resources for health promotion, prevention and care. The issue is one of reducing inequalities in health, not only in access to health care and the authors suggest that a rights-based framework provides the necessary social and political leverage to advance the health equity agenda as promoted in human rights and legal frameworks. The integration of human rights and health might not be high on the agenda of Papua New Guinea and its major donors but as Gruskin, Mills & Tarantola (2007) emphasise, public-health efforts that consider human rights are likely to be more effective than those that neglect or violate rights. Papua New Guinea will not achieve sustained progress or achieve its commitment to the Millennium Development Goals without recognising human rights principles as core principles of health policy and health care delivery in the country.

Acknowledgements

We thank the women in the Wosera for their participation in this study, Alma Auwun, PNGIMR Operational Research Unit Research Assistant for her valued contribution and assistance and other staff of the PNGIMR in Maprik for their assistance and support.

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